Early Infectious Syphilis

Male Homosexual Relations as a Mode of Spread

JOHN D. F. TARR, *M.D.*, and ROBERT R. LUGAR, *B.A.*, Los Angeles

• **Homosexual relations play an important part in the transmission of infectious syphilis. A preponderance of the males with infectious syphilis treated in Los Angeles City Health Department clinics in 1959 admitted to exclusively homosexual relations during the period in which they became infected.**

In the interviewing of males with infectious syphilis, inquiry should routinely be made relative to possible homosexual relations, for investigation of the sexual partners of homosexual males is particularly productive in terms of new case finding.

The practicing physician's awareness of the epidemiological significance of homosexual activity will influence his degree of clinical suspicion, his attitude in the physician-patient relationship and his concept of the opportunity and responsibility of bringing to examination the infected patient's sexual partners.

THAT HOMOSEXUAL RELATIONS play a large part in the spread of infectious syphilis in the City of Los Angeles was demonstrated by the results of a recent study. The findings assume additional importance in view of recent increases in the prevalence of early infectious syphilis. The significance of male homosexual activity as an important factor in the transmission of venereal disease deserves recognition by both practicing physicians and public health agencies.

In an attempt to evaluate quantitatively the contribution of male homosexual activity to the total problem of infectious syphilis as experienced locally, an investigation of morbidity reports and medical records maintained by the Los Angeles City Health Department was instituted. In the calendar year 1959 a total of 292 persons residing within the city limits of Los Angeles were reported as having primary or secondary syphilis. Private physicians reported 96 (32.9 per cent) of these cases and the remaining 196 or 67.1 per cent were diagnosed in venereal disease clinics operated by the city. Each of the nine venereal disease clinics operated in the nine district health offices of the City Health Department reported some cases, although not in equal distribution. A standardized routine is established for the diagnosis, treatment and follow-up care of patients with venereal infections, and uniform records are maintained in these clinics.

The series of patients considered in this study —194 persons with primary or secondary syphilis —comprises all patients diagnosed as having primary or secondary syphilis during the calendar year 1959 in city-operated clinics. Records on two other patients were not available.

In a review of the literature and of our patient records, no report was found of the transmission of any venereal infection as the result of homosexual relations between females. Hence this study is restricted to the role of male homosexual relations in disease transmission.

Of the 194 patients diagnosed with infectious syphilis, 170 or 87.6 per cent were males.

All patients in whom the diagnosis of primary or secondary syphilis is established are routinely interviewed at the time of diagnosis by medical interviewers to elicit the names and addresses of persons with whom they have had sexual contact—persons from whom the infected patient could have acquired the disease or to whom, once having become infected, he could have transmitted the disease. Uniform interviewing techniques are used. Those sexual contacts who are located by medical investigators are referred to their private physicians or to city clinics for examination and treatment. The location of potentially infected contacts of patients with infectious syphilis is considered a high priority effort by the public health agency.

Only 11 of the patients interviewed were unable or unwilling to identify at least one person with whom they had had sexual contact. Of the 159 males who revealed the identity of sexual partners, 89 (56 per cent) named only male sexual contacts, 21 (13.2 per cent) indicated that they had had sexual relations with both males and females and 49 (30.8 per cent) named exclusively female sexual partners.

It is interesting to note that these seemingly startling figures are readily accepted by the physicians, nurses and medical investigators working in the venereal disease clinics. It has been their subjective impression that in recent years a decided increase was being seen in homosexual patients who had become infected with venereal disease. Con-

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TABLE 1.—*Number of Cases of Primary and Secondary Syphilis by Year in Five West Coast Metropolitan Areas (1955-1959)*

City	1955	1956	1957	1958	1959	Per Cent Change 1955-59
Los Angeles City	70	58	113	223	274	+291.4
San Francisco	45	89	124	144	311	+591.1
Portland	26	11	10	6	9	− 65.4
Seattle	15	18	13	14	36	+140.0
Los Angeles County excluding Los Angeles City	27	39	33	51	57	+111.1

Source: U. S. Public Health Service—Figures compiled for fiscal years of the political units listed, in contradistinction to figures elsewhere in this article, computed on calendar year basis.

siderable effort is made to expeditiously locate and bring to examination each individual named as a sexual contact. The diagnosis of syphilis in a person named as a contact serves to authenticate the reliability of the information which identified the contact as a sexual partner.

The interviewer seeks to identify the persons who participated in sexual intercourse with the infected patient during the period in which the patient could have acquired or transmitted the disease. This period is three months before the onset of symptoms in the case of primary syphilis and six months before the onset of symptoms in secondary syphilis.

The 89 males who participated exclusively in homosexual relations during the period covered by the interview named 551 different persons as sexual partners. The average number of different sexual partners per patient during the presumably communicable period—6.26 in the present study—is referred to as the contact index. This does not represent the total number of sexual episodes, but the number of different named persons with whom there was at least one sexual episode. The 49 males who had exclusively heterosexual relations identified 137 sexual partners—a contact index of 2.79. These figures would tend to confirm the impression of workers in the venereal disease clinics in Los Angeles, that, in general, exclusively homosexual males of the type seen in clinic are more promiscuous than the exclusively heterosexual males. The largest number of sexual partners reported by any one infectious male patient was 48, all of them males. Investigation of those exposed by this one patient brought to treatment five additional patients with active syphilis.

How many persons would have syphilis and not know it except for the contact investigations can only be conjectured. Among the persons who had had sexual contact with the 89 exclusively homosexual patients in the present series, 93 were found to have syphilis. This ratio, expressed as an epidemiological index, was 1.04. The epidemiological index for exclusively heterosexual males was 0.59.

Treating the patient alone does not represent the culmination of the physician's responsibility. Locating and examining persons who have had sexual contact with infected patients is essential for the eradication of syphilis. This is particularly urgent in view of recent increases in the incidence of infectious syphilis (see Table 1). It is our impression that the majority of the increase in Los Angeles between 1955 and 1959 was due to homosexual transmission of infectious syphilis.

Homosexual acts are prohibited by law and punishable as felonic in the State of California with a maximum possible sentence of 15 years' imprisonment for oral copulation and life imprisonment for sodomy (California Penal Code, 1959, Sections 288A and 286). In practice, however, homosexuals apprehended are often permitted to plead guilty to the minor charges of disturbing the peace (California Penal Code Section 415) or injuring the person or property of another (Section 650½) or vagrancy and lewd conduct (Section 647.5) with much less severe penalties. An additional requirement may be that the accused person register as a sex offender.

The legally contravened nature of homosexual copulation thus places additional importance on the confidentiality of the physician-patient relationship. Patients who have venereal disease as a result of homosexual relationships may very understandably be reluctant to disclose the manner of infection or the identity of others whom they may have infected. Any impression of collusion between law enforcement agencies and medical treatment agencies detracts from the effectiveness of case-finding among homosexual patients by rendering the patient and his sexual partners suspicious, uninformative and purposely misleading. Word of the trustworthiness of physicians and public health agencies appears, however, to spread rapidly in homosexual circles.

In view of patients' reluctance to spontaneously admit the mode of infection, it becomes imperative for physicians to possess a clinical index of suspicion directed toward the detection of the atypically located venereal lesion. The possible clinical significance of seemingly innocuous complaints such as rectal discomfort, discharge or minor fissure is apparent. Evaluation by anoscopy is to be considered in male patients suspected of venereal disease or homosexual activity.

The usual homosexual patient seen in Los Angeles City venereal disease clinics is a young white male of average or above-average socio-economic status. In acts involving sodomy or fellatio he may be either the aggressor or the recipient.

The patient presenting himself for treatment of a venereal infection acquired through homosexual relations may represent any one of a multiplicity of behavior patterns derived from the broad continuum of homo-heterosexual preferences. He may possess no feminine mannerisms and not be identifiable by physical appearance or demeanor. Conversely his feminine traits and characteristics may be conspicuous and immediately apparent. His behavior may be extremely promiscuous, as typified by the aggressor male who may have both male and female contacts and who possesses the dubious distinction of achieving the highest number of sexual contacts of any homosexual patient. On the other hand, two males may establish a stable relationship and live *en menage* for varying periods of time. Proceeding down the scale from passive amateur to female impersonator, male prostitute, and husband and wife relationship, there is seen a significant decrease in the number of contacts. It follows that less venereal disease is found among the more discriminating individuals. There may be no attempt to conceal homosexual inclinations and preferences, or a patient may be married and utilize his marital status to supply the guise of conformity.

It is thus apparent that attempts to identify a male as homosexual based upon physical appearance or mannerisms or marital status are futile. There is a broad spectrum of behavioral activity ranging from the exclusively heterosexual to the exclusively homosexual, and all shades of gradation are represented between the two extremes.

Due to the multiplicity of modes of sexual contact, primary syphilitic lesions contracted through homosexual activity may be present on the penis, scrotum, inguinal area, para-anal tissues, rectum or mouth. A rectal chancre will readily infect a sexual partner's external genitalia and this is the mechanism of homosexual transmission most frequently encountered.

As in any interpersonal relations, the physician's attitude toward the homosexual patient is of importance in the therapeutic process. The desirable sympathetic approach toward patients may be complicated by the physician's own attitudes, emotions and judgments relating to homosexual activity. An awareness of his own attitudes and feelings will facilitate a nonjudgmental physician-patient relationship.

It is interesting to note that there appears to be a diminished suspicion toward the hazard of contracting venereal disease on the part of some homosexual patients, which results from the erroneous concept that venereal disease is more likely to be associated, or is exclusively associated, with heterosexual relations. The reeducation of patients who have this misconception is important and is inherent in the responsibility of the physician.

Los Angeles City Health Department, 111 East First Street, Los Angeles 12 (Tarr).